

**\*This form must be printed, hand-written and signed by a health care provider.**



Dear New Student,

Welcome to Sacred Heart University! We hope your experience here will be a healthy and happy one.

The State of Connecticut requires that we collect some basic health information before you begin your studies. *All new students, unless you are a distance learner (online classes only), must submit these forms.* It is your responsibility alone to make sure that we have received all the required information – failure to comply with the State requirements will result in your student account being blocked, prohibiting you from registering for classes AND entry into university housing.

Please read the information below carefully and completely and follow all instructions. Feel free to call us with any questions or concerns at 203-371-7838 or email us at [healthservices@sacredheart.edu](mailto:healthservices@sacredheart.edu).

**A. Checklist:** Please use this checklist to assist you in completing the New Student Health Form

- Print out this form in its entirety.
- Complete Section I (Tuberculosis High Risk Screening Questionnaire) and sign form in space provided.
- Bring the form to your healthcare provider and have them fill out Sections II (TB Screening Test, if required), III (Immunization History), and IV (Clinician Information). *The New Student Health Form must be signed, dated and stamped by your healthcare provider.*
- Scan or take a photo of the completed form (and all supporting documents given to you by your healthcare provider).
- Log in to your [Student Health Portal](https://myhealth.sacredheart.edu) (<https://myhealth.sacredheart.edu>) with your SHU username and password and follow all instructions on the home page. You will be required to upload this form to the Portal. **DO NOT MAIL, EMAIL OR FAX YOUR FORMS!**
- Await review and verification of your uploaded forms (this can take up to 10 business days), then make sure to check your messages in the Student Health Portal ("Messages" tab) or your SHU email and respond to any requests for further information or corrective action.

**All health forms must be submitted by JULY 15<sup>TH</sup> FOR FALL SEMESTER (or 4 weeks prior to the start of classes for all other start dates)**

**B. Required Vaccinations/Screening (updated 1/2023)**

The following are required by the State of Connecticut and Sacred Heart University:

1. MMR (Measles, Mumps and Rubella) Vaccine: Two doses of each Measles, Mumps and Rubella vaccines (or the combined MMR vaccine) administered at least 28 days apart with the first dose **ON** or **AFTER** your first birthday **OR** evidence of immunity to Measles, Mumps and Rubella via blood titers – lab reports are required. Required for all students born after 1956.
2. Varicella (Chicken Pox) Vaccine: Two doses administered at least 28 days apart with the first dose **ON** or **AFTER** your first birthday **OR** documentation of date of Varicella disease signed by your healthcare provider **OR** evidence of immunity to Varicella via blood titers – lab reports are required. Required for all students born after 1979.
3. Meningitis ACYW Vaccine: One dose within the past 5 years *only if you will be living in the SHU residence halls.*
4. Tuberculosis (TB) Screening Questionnaire: You must fill out this questionnaire and based on your answers, you may be required to have skin or blood TB testing.

For information on exemptions to the required vaccinations, please see the CT State Department of Public Health website section on Immunization Laws and Regulations: <https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations>.

**C. Recommended Vaccinations**

The following vaccines are strongly recommended by Sacred Heart University: COVID-19, Hepatitis A, Hepatitis B, HPV, Meningitis B, and Tdap.

**D. Programs Requiring Additional Health Forms**

Some students are required to submit additional health forms for their specific program of study or sport. For instance, D1 athletes must submit NCAA health forms to the Athletics Department, Nursing and some health science students must submit "CastleBranch" or "PreCheck" forms to their program, and so on. *Your program will notify you about any additional required health forms.* Even if you have submitted health forms to the Athletics department or your program of study, **you are still required to submit health forms to Student Health Services since we are required by law to collect this information.**

## Sacred Heart University New Student Health Form (Page 1 of 2)

Submit all completed forms and any supporting documents by uploading to the Student Health Portal - <https://myhealth.sacredheart.edu>

Student Last Name	Student First Name	Student Middle Name
Date of Birth	Gender Identity Sex Assigned at Birth	SHU ID#
Date Beginning School: <input type="checkbox"/> Fall 20____ <input type="checkbox"/> Spring 20____ <input type="checkbox"/> Commuter <input type="checkbox"/> Campus Housing <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate		
Student's Cell Phone	Student's Preferred E-mail Address	

### SECTION I: TUBERCULOSIS HIGH RISK SCREENING QUESTIONNAIRE

**Student: Please answer questions 1 through 4 then follow instructions below**

1. Have you ever had a positive tuberculosis (TB) skin or blood test in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. To the best of your knowledge, have you ever had close contact with anyone who was sick with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Were you born in one of the countries listed below? <i>If yes, which country?</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you spent more than one month in one or more of the countries listed below?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered NO to all questions above, no further testing is required. Please sign below.**

**If you answered YES to any question above, you must have a TB skin or blood test documented by your healthcare provider (see Step 1). No exemption for prior BCG. Please sign below.**

**By signing below, I confirm that all the information provided in this form is accurate.**

Student Signature  <b>X</b>	Date
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### SECTION II: TB SCREENING TEST To be filled out by healthcare provider

TB screening test *only required* if student answers YES to any of the above questions. Healthcare provider must document test results and sign below. All TB skin or blood tests must be done **within 1 year** prior to the start of school.

STEP 1: TB SKIN TEST (PPD) <span style="color: red;">OR</span> TB BLOOD TEST/IGRA*	STEP 2: CHEST X-RAY <span style="color: red;">AND</span> MEDICATION TREATMENT
Date PPD Planted: _____ Date PPD Read: _____ Interpretation: <input type="checkbox"/> NEG <input type="checkbox"/> POS mm of induration: _____ <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot Date: _____ Result: <input type="checkbox"/> NEG <input type="checkbox"/> POS <small>*preferred with previous BCG. Lab report required.</small>	<div style="color: red; font-weight: bold; font-size: small;">Required only if past or current positive TB skin or blood test. Chest x-ray should be done within one year of the positive skin/blood test. Radiology report must be included.</div> Medication(s) Used:  Dates Administered:  Chest X-ray Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
If PPD or IGRA test is Negative, no further testing required. If test is Positive, proceed to Step 2. <span style="color: black; font-weight: bold;">➔</span>	

Healthcare Provider Signature  <b>X</b>	Date	Healthcare Provider Name and Title (print)
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#### List of High Risk Tuberculosis Countries for TB Questionnaire above

Afghanistan	Bulgaria	Democratic Republic of the Congo	Guam	Lesotho	Myanmar	Republic of Korea	Togo
Algeria	Burkina Faso	Djibouti	Guatemala	Liberia	Namibia	Republic of Moldova	Tokelau
Angola	Burundi	Dominica	Guinea	Libya	Nauru	Romania	Tunisia
Anguilla	Côte d'Ivoire	Dominican Republic	Guinea-Bissau	Lithuania	Nepal	Russian Federation	Turkmenistan
Argentina	Cabo Verde	Ecuador	Guyana	Madagascar	Nicaragua	Rwanda	Tuvalu
Armenia	Cambodia	El Salvador	Haiti	Malawi	Niger	Sao Tome and Principe	Uganda
Azerbaijan	Cameroon	Equatorial Guinea	Honduras	Malaysia	Nigeria	Senegal	Ukraine
Bangladesh	Central African Republic	Eritrea	India	Maldives	Niue	Sierra Leone	United Republic of Tanzania
Belarus	Chad	Eswatini	Indonesia	Malta	Northern Mariana Islands	Singapore	Tanzania
Belize	China	Kazakhstan	Iraq	Marshall Islands	Pakistan	Solomon Islands	Uruguay
Benin	China, Hong Kong SAR	Kenya	Kiribati	Mauritania	Palau	Somalia	Uzbekistan
Bhutan	China, Macao SAR	Kiribati	Kuwait	Mexico	Papua New Guinea	South Africa	Vanuatu
Bolivia (Plurinational State of)	Colombia	Kyrgyzstan	Kyrgyzstan	Micronesia (Federated States of)	Paraguay	South Sudan	Venezuela
Bosnia and Herzegovina	Comoros	Lao People's Democratic Republic	Lao People's Democratic Republic	Mongolia	Peru	Sri Lanka	(Bolivarian Republic of)
Botswana	Congo	Latvia	Latvia	Morocco	Philippines	Sudan	Viet Nam
Brazil	Democratic People's Republic of Korea			Mozambique	Qatar	Suriname	Yemen
Brunei Darussalam						Tajikistan	Zambia
						Thailand	Zimbabwe
						Timor-Leste	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population

Please continue to page 2

## Sacred Heart University New Student Health Form (Page 2 of 2)

Submit all completed forms and any supporting documents by uploading to the Student Health Portal - <https://myhealth.sacredheart.edu>

Student Last Name:	Student First Name:	Date of Birth:
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### SECTION III: IMMUNIZATION HISTORY To be filled out by healthcare provider only; will accept printed vaccine record

**MEASLES, MUMPS, RUBELLA (MMR) VACCINATION** - Dose #1 on or after first birthday, dose #2 at least 28 days later; Required if born after 1956.

<b>OPTION 1:</b> <b>OR</b>	Measles, Mumps, Rubella (MMR) Vaccination	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY
<b>OPTION 2:</b> <b>OR</b>	Measles Vaccination <b>AND</b> →      Mumps Vaccination <b>AND</b> →      Rubella Vaccination Dose #1      Dose #2      Dose #1      Dose #2      Dose #1      Dose #2 MM / DD / YYYY      MM / DD / YYYY      MM / DD / YYYY      MM / DD / YYYY      MM / DD / YYYY      MM / DD / YYYY		
<b>OPTION 3:</b>	Measles Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not immune      Date _____ MM/DD/YYYY Mumps Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not immune      Date _____ MM/DD/YYYY Rubella Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not immune      Date _____ MM/DD/YYYY *If not immune, you are required to get 2 MMR vaccines separated by at least 28 days		ATTACH ALL LAB REPORTS

**VARICELLA VACCINATION** - Dose #1 on or after first birthday, dose #2 at least 28 days later; Required if born after 1979.

<b>OPTION 1:</b> <b>OR</b>	Varicella Vaccination	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY
<b>OPTION 2:</b> <b>OR</b>	Varicella Titer Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not immune      Date _____ MM/DD/YYYY *If not immune, you are required to get 2 Varicella vaccines separated by at least 28 days		ATTACH ALL LAB REPORTS
<b>OPTION 3:</b>	An incidence of disease will take the place of a vaccine requirement (Must be filled in by a physician/DO/APRN/PA)	Varicella (Chicken Pox) Disease (Date required) MM/DD/YYYY	

**MENINGOCOCCAL VACCINATION** - Required of all students living in University housing

Meningococcal Vaccination Must cover strains A, C, Y, W-135	Date MM / DD / YYYY	Vaccination must have been given within 5 years of the first day of classes at SHU.
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### RECOMMENDED VACCINATIONS

HEPATITIS A	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY		TETANUS, DIPHTHERIA, PERTUSSIS (within the last 10 years)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td	Date MM / DD / YYYY
HEPATITIS B	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	Dose #3 MM / DD / YYYY	COVID-19 Please indicate vaccine type given for each dose	Dose #1 MM / DD / YYYY	Vaccine type given
HUMAN PAPILOMAVIRUS (HPV)	<input type="checkbox"/> HPV4 <input type="checkbox"/> HPV9	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	Dose #3 MM / DD / YYYY	Dose #2 MM / DD / YYYY	_____
MENINGOCOCCAL SEROGROUP B	<input type="checkbox"/> Trumenba <input type="checkbox"/> Bexsero	Dose #1 MM / DD / YYYY	Dose #2 MM / DD / YYYY	Dose #3 MM / DD / YYYY	Dose #3 MM / DD / YYYY	_____

### SECTION IV: CLINICIAN INFORMATION To be filled out by healthcare provider

***By signing below, I confirm that the above information is accurate to the best of my knowledge and that this student has no medical condition that would prohibit him/her/them from participating fully in all educational activities. This is NOT a clearance for D1 or club sports.***

Healthcare Provider Signature  <b>X</b>	Date	Office Address and Phone #
Healthcare Provider Name and Title (print)		Office Stamp

NAME:  
BIRTH DATE:  
MRN:  
DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

**Yale New Haven Health  
& Yale Medicine**  
**Patient Acknowledgement  
and Financial Authorization**

**A. CONSENT FOR TREATMENT:** I<sup>1</sup> consent to being admitted/treated as a patient of Yale New Haven Health (“YNHH”) and Yale Medicine (“YM”) for the purpose of receiving medical care and treatment and/or diagnostic procedures. I understand and agree that: (i) YNHH and YM are teaching institutions and students may be involved in observing and giving care unless I disagree; (ii) all attending physicians have privileges to practice at YNHH facilities, but not all physicians are agents or employees of YNHH or YM; (iii) I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me; (iv) as part of my medical care and treatment I may be tested for HIV, and that this testing is voluntary. I will notify my care provider if I do not agree to HIV testing; and (v) photographs, videotaped images or other images may be made of me for purposes of medical documentation or education as YNHH, YM or its medical staff deem appropriate. I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the institution only with my written authorization or that of my legal representative; (vi) the institution may use audio/video monitoring to enhance my care in some locations or video monitoring for patient safety; (vii) leftover blood, fluids or tissue may be used for scientific research or teaching by appropriate persons and that I will no longer have any rights to them.

**B. AUTHORIZATION FOR PAYMENT/FINANCIAL AGREEMENT:** I agree to pay YNHH and YM for all services and supplies provided to me, and for any other applicable charges. I authorize and direct my insurance carrier, health sharing ministry, discount plan or another entity (“Payor”) to make payment to YNHH and YM of all insurance or other benefits, including authorized Medicare benefits, and assign my rights to YNHH and YM. I have requested that YNHH and YM first seek payment for the medical services provided from such Payor. I understand that by agreeing to do so, YNHH and YM have not agreed to accept less than full payment of amounts due and owing from any such entity unless YNHH and YM have an existing contract with such entity to accept reduced payment for the services provided. Regardless of what my identification card says, I understand and agree that I may be billed, and will be obligated to pay, for any such amount not paid by my Payor, to the extent permitted by law. I agree to pay any remaining balance not covered by my insurance plan or not paid by any Payor. If I receive payment from my insurance company or other Payor for services provided to me by YNHH and YM, I agree to submit the payment to the hospital and/or YM. If my account is not paid, I will pay all costs incurred as a result of YNHH’s and/or YM’s collection efforts, including, without limitation, attorneys’ fees and court costs. As a courtesy, YNHH or YM may assist me in processing insurance claims, however, YNHH and YM accept no responsibility for any processing procedures, acts, omissions or neglect. Any amounts not paid by my insurer become due and payable when the bill is mailed or on demand. If my bill is not paid in full, YNHH and YM reserve the right not to provide any future non-emergency medical services to me. YNHH has a Charity Care program for eligible persons who do not have insurance or cannot pay bills. To be considered for Charity Care, I may need to apply to Medicaid and meet other requirements.

**C. SEPARATE HOSPITAL & PHYSICIAN SERVICES:** I understand that when I am treated in a Hospital or in a Hospital Outpatient Department that I will

receive separate bills for hospital services and physician services, which I would not receive if the services were provided in an office that is not hospital-based. I understand that I will be subject to separate coinsurance liabilities for each separate bill, and that additional information, including an estimate of my out-of-pocket liability, is available to me at each Hospital facility. I understand that this consent and authorization applies to physician services, as applicable, to the same extent as it applies to YNHH and YM.

**D. RELEASE OF INFORMATION:** I understand that YNHH and YM can release all necessary health information for purposes of treatment, payment and healthcare operations. I authorize the release of any HIV/AIDS-related information, drug and alcohol abuse treatment information, and information about diagnosis or treatment of mental illness, to other treating providers and to third-party payers, including but not limited to insurance companies, managed care organizations, Medicare, Medicaid, and other governmental payors. I understand that YNHH and YM may release any and all necessary information with respect to my treatment when required to do so by law, including the mandatory reporting of certain communicable diseases (including but not limited to tuberculosis and HIV) to the State Department of Public Health.

I understand that refusal to consent to release of health information will not jeopardize my right to obtain present or future treatment, except where disclosure is necessary for the treatment. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. The authorization provided in this Section D expires one year from the date of discharge from the Hospital if inpatient, or one year from the last date of treatment in an outpatient department or physician office. I understand that if I refuse to authorize release of information and this results in a refusal by my insurance company or other responsible payor to pay YNHH or YM for my treatment, I will be responsible for the entire unpaid portion of my bill.

**E. COMMUNICATIONS VIA PHONE:** If I have provided a telephone number as a primary telephone contact, I hereby authorize YNHH and YM, along with their respective employees, agents, and business associates, to contact me via phone or text message for any reason, including, without limitation, automated notifications and appointment reminders.

**F. PERSONAL VALUABLES:** I hereby understand and acknowledge the following: (i) I accept sole responsibility for all personal property retained by me in a YNHH or YM facility; (ii) I have been advised not to keep any valuables with me while I am a patient of a YNHH or YM facility; (iii) neither YNHH nor YM is responsible for any lost items; (iv) for inpatient or outpatient stays, the use of a security vault may be available upon my request, and I must sign an additional form for its use; and (v) YNHH and YM reserve the right to inspect and to prohibit inappropriate or unsafe items, such as drugs, alcohol, weapons, cellular phones, etc.

**G. TELEHEALTH:** I understand that Yale New Haven Health and Yale Medicine may use telehealth tools to enhance my care, and/or ensure my safety, and that of my care team. These tools may include, but are not limited to asynchronous communications or evaluations between consulting providers as well as interactive audio/video technologies and monitoring that allow my caregivers to assess my current presentation and provide care virtually.

\_\_\_\_\_ the \_\_\_\_\_ hereby give consent on his/her behalf  
Printed Name of patient / patient representative

\_\_\_\_\_  
Time Date Signature of patient / patient representative Printed Name of patient / patient representative

**Interpretation Services (if necessary):** An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in \_\_\_\_\_ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: \_\_\_\_\_ AM/PM Date: \_\_\_\_\_

**Check here if:**  Telephone  Video  In person  Bilingual Competency Program Approved Staff

**ID Number:** \_\_\_\_\_

Print Name of Interpreter

<sup>1</sup> “I” shall mean the patient or the individual authorized to sign on behalf of the patient



# Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our privacy office at the phone number at the bottom of this notice.**

## **Our pledge to you:**

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

## **How we may use and disclose medical information about you:**

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to

improve treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies. Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protection. For more information on research and how to opt out of research use of your records see [www.yalestudies.org](http://www.yalestudies.org) or 1-877-978-8343.

If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

#### Other uses of Medical Information:

In any other situation not covered by this notice, including the use or disclosure of psychotherapy notes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

### Who will follow this notice?

Yale New Haven Health System (YNHHS) and Yale School of Medicine (YSM) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of our locations
- All departments and affiliated covered entities of Yale New Haven Health System, including; Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group, Westerly Hospital, Lawrence + Memorial Hospital, and Yale-New Haven Hospital
- Yale School of Medicine
- The clinical care providers of Yale School of Nursing as well as their affiliates
- All employees, medical staff, affiliates, trainees, students, or volunteers of the entities listed above

While each of these facilities and affiliates operates independently, they may share your health information for coordination of care, treatment, payment, and healthcare operations purposes.

### Right to Be Notified of a Breach:

We will notify you in the event that the confidentiality of your information has been breached.

### Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in advance, in writing. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

### Right to an Accounting:

You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions, as required by law.

To request this list of disclosures, indicate the relevant period which must be within the past six years. You must submit your request in writing to the Medical Record or Billing Department as appropriate.

### Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it unless all of the conditions below are met:

- You request that your information is not shared with an insurer for purposes of payment or other purposes unrelated to your treatment;
- You pay all charges associated with the services you received out-of-pocket in full; and
- We are not required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

**Requests for Confidential Communications:**

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

**Right to request a paper copy of this Notice:**

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

**Changes to this Notice:**

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at [yalenewhavenhealth.org](http://yalenewhavenhealth.org). You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

**Complaints:**

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

**YNHHS OFFICE OF  
PRIVACY AND COMPLIANCE**  
203-688-8416  
Toll Free: 1-888-688-7744  
[privacy@ynhh.org](mailto:privacy@ynhh.org)

**Yale University HIPAA  
Privacy Office**  
203.432.5919  
[hipaa@yale.edu](mailto:hipaa@yale.edu)

**Y A L E N E W H A V E N H E A L T H S Y S T E M**

*Acknowledgement of Receipt of Notice Of Privacy Practices*

Printed Name of Patient: \_\_\_\_\_

Patient's Medical Record Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's Personal Representative & Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If Applicable, Reason for Patient Refusal to Sign: \_\_\_\_\_

VERSION EFFECTIVE: 08/20/18



**Interpretation Services (if necessary):** An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in \_\_\_\_\_ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: \_\_\_\_\_ AM/PM    Date: \_\_\_\_\_

**Check here if:**     Telephone     Video     In person     Bilingual Competency Program Approved Staff

\_\_\_\_\_  
Print Name of Interpreter

**ID Number:** \_\_\_\_\_